BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: JUNG WON S., Claimant, vs. REGIONAL CENTER OF THE EAST BAY, Service Agency.	OAH No. 2010090260

DECISION

Administrative Law Judge Diane Schneider, Office of Administrative Hearings, State of California, heard this matter in Concord, California, on March 8, 9, 10, 21, 22, 23, and 24, 2011.

Jessica Cochran, Attorney at Law, represented claimant Jung Won S.

Pamela K. Higgins, Fair Hearing Specialist, represented Regional Center of the East Bay (RCEB), the service agency.

Submission of the case was deferred pending receipt of closing briefs. Claimant's closing brief was marked for identification as Exhibit P16. RCEB's closing brief was marked for identification as Exhibit 81. Claimant's reply to RCEB's closing brief was marked for identification as Exhibit P17.

The record closed, and the matter was submitted for decision on May 16, 2010.

ISSUE

Is claimant eligible for regional center services because he has Autistic Disorder, or because he has a condition closely related to mental retardation, or has a condition that requires treatment similar to that required for individuals with mental retardation?

FACTUAL FINDINGS

Introduction

1. Jung Won S. (claimant) applied to RCEB for regional center services in 2009. Following evaluations by two assessment teams RCEB notified claimant of its decision, in a Notice of Proposed Action dated August 12, 2010, that he was not eligible for regional center services. Claimant appealed, and this hearing followed.

2. By all accounts, claimant presents with a complex set of longstanding psychological and developmental problems that defy neat categorization. He contends that he is eligible for services because he suffers from Autistic Disorder, or under what is commonly referred to as the fifth category, because he has a disabling condition that is either closely related to mental retardation or which requires treatment similar to that provided to individuals with mental retardation. He claims that as a result of his executive dysfunction and Pervasive Developmental Disorder Not Otherwise Specified (PDD/NOS),[1] his adaptive functioning skills are on par with someone who is mentally retarded. He claims that he requires treatment similar to that required for individuals with mental retardation, such as independent living skills, vocational and social skills training.

RCEB's principal contention is that claimant does not suffer from a developmental disability, but suffers instead from Schizophrenia; and, that his difficulties in adaptive functioning stem from this psychiatric condition rather than a developmental disorder. While the evidence established that claimant has psychiatric problems, the evidence failed to support RCEB's theory that claimant has Schizophrenia or that his difficulties in adaptive functioning stem solely from a psychiatric condition.

Although all of the experts offered credible testimony, the analyses offered by claimant's experts, who were most familiar with claimant's capabilities and limitations, were ultimately the most persuasive. The weight of their testimony established that claimant suffers from PDD/NOS, a Pervasive Developmental Disorder, that is substantially disabling

[1] PDD/NOS is a "severe and pervasive impairment in the development of reciprocal social interaction associated with impairment in either verbal or nonverbal communication skills or with the presence of stereotyped behavior, interests, and activities" but the criteria are not met for a specific Pervasive Developmental Disorder. (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), at p. 84.)

and that requires treatment similar to that required for individuals with mental retardation.[2] Accordingly, claimant is eligible for regional center services under the fifth category. While claimant has received long-standing psychiatric treatment for anxiety and other issues relating to his mood, the evidence did not establish that he suffers from Schizophrenia.

The evidence presented was voluminous. The pertinent facts are summarized below.

Claimant's Evidence

Developmental and Academic History[3]

3. Claimant was born in Korea on August 8, 1977. When claimant lived in Korea, he had rubella and suffered from grand mal seizures.[4] His family, which includes his parents, an older sister (Ki-Young Suh, M.D.) and a younger sister (Eul Hui), immigrated to the United States when claimant was about five years old. Relatives always referred to claimant as "awkward." He had coordination difficulties beginning when he was a toddler. He was slow to walk and crawl. He did not start walking until he was two years old. He also had delays in language, and he spoke with a stutter. He did not begin using words until he was approximately three years old, and he did not begin speaking in sentences until he was about five years old.[5]

He had fine motor difficulties, evidenced by his problems coloring, tracing, and using scissors. He also struggled with performing tasks that took two steps. Claimant had trouble becoming toilet-trained, and he was not independent in toileting until late elementary school.

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[2] Pervasive Developmental Disorders, as described in the DSM-IV-TR, are "characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests and activities." (DSM-IV-TR, at p. 69.) Pervasive Developmental Disorders are often referred to by the experts herein as Autistic Spectrum Disorders (ASD).

[3] The information contained herein is based largely on the reports of claimant's mother as told to various mental health professionals who interviewed her, and on the observations of claimant's sisters, who testified at the hearing. RCEB Staff Physician Paul Fujita, M.D., questioned the credibility of the information provided by claimant's sisters. He suggests that they were "not completely" forthcoming with information and that the information they did provide was inconsistent. Dr. Fujita's view is unsupported by the record. Claimant's sisters made their best efforts to provide RCEB with all available documents, and their testimony at the hearing was forthright and credible in all respects.

[4] One expert suspects that claimant's PDD/NOS was caused by his seizures. (Factual Finding 33.)

[5] He reportedly struggled with speaking in sentences until he was about seven years old.

His mother reported that claimant was unable to learn how to shower correctly until high school.

4. Claimant had poor social skills from a young age. He did not play with other children. In school, he was ostracized and bullied. Claimant was also unable to engage in reciprocal relationships with his family members, who cared for him.

An Individualized Educational Program (IEP) record from claimant's high school indicates that he received special education services since the eighth grade for a speech impairment, described as a "stammering speech problem." Claimant was described as someone with a low frustration tolerance, who was emotionally fragile and socially anxious.

5. In 1995, he took the Wechsler Adult Intelligence Scale (WAIS-R). Claimant's Verbal IQ was 121 (high average), his Performance IQ was 85 (low average), and his Full Scale IQ was 101 (average). Other intelligence tests administered suggested similar results placing him, overall, in the average range of intelligence, with weak receptive or nonverbal language skills.

6. Dr. Suh helped claimant navigate his way through school, including helping with homework, until she left home for college. Claimant had great rote memory and was able to do simple math and history. Dr. Suh explained that she "took over" for claimant, however, when he was required to synthesize material, a task that he could not perform. Since a lot of his grades were based upon homework, her help enabled him to maintain A's, B's and C's. When claimant was a junior in high school, she left for college, and his grades dropped to mostly D's and F's. Claimant was, however, able to graduate from high school.

7. Claimant had several unusual habits: He was preoccupied with World War II, and with razor blades, which he sometimes shoplifted. He also insisted on using different bars of soap to wash his buttocks and the rest of his body.

8. Claimant's parents had high expectations for their children. Claimant's parents did not understand claimant's problems. They thought his failure to progress stemmed from personal choice rather than inability. Dr. Suh recounted that because of the negative stigma associated with developmental disabilities in her culture, "any label of developmental disability was out of the question." Claimant's family did not seek out help for claimant when he was a child because they held out "false hope" that claimant would grow out of his difficulties. When claimant was 23, his mother expressed her hope that claimant would "get cured." Claimant's parents now accept that claimant needs life-long support for his problems.

Post High School and Move to Alaska

9. After claimant graduated high school, he lived with parents. Claimant has acted out in anger, sometimes violently, towards his family. As a result, he had two brief psychiatric hospitalizations in 2002 and 2005.

10. Feeling a need to be more independent, he left for Alaska in 2007, without any plan as to how he would survive. When he arrived in Alaska, he did not find work and was homeless. He stayed in Alaska until 2009, and during this time, had several contacts with the criminal justice system. As a result, he spent time in jail, and in the jail psychiatric unit. During his stay in Alaska, claimant also resided in a board and care home.

Current Placement

11. Claimant has never been able to function independently. After his parents arranged for his return to California in 2009, he applied for, and was accepted into the Center for Adaptive Learning (CAL), a supportive living program for people with developmental disabilities. Currently, claimant lives at CAL, where he shares an apartment with a roommate and receives help with independent living skills such as shopping, meal preparation, and cleaning. Claimant has never held down a job, and he receives social security disability.

Evaluations by Psychologists and Psychiatrists

12. Claimant began psychiatric treatment when he was in high school, and was prescribed anti-depressants. He has had ongoing psychological treatment and a variety of psychiatric diagnoses, including Anxiety Disorder, Major Depression, Mood Disorder, Schizoaffective Disorder and Schizophrenia.

13. Doni Kwak, Ph.D.: In August 1999, when claimant was 22 years old, he was evaluated and treated by Dr. Kwak, who was then a psychologist at the Asian Pacific Counseling and Treatment Center (APCTC). Dr. Kwak diagnosed claimant with Asberger's Disorder based upon the following factors: Claimant had a long history of difficulties with peer relationships and social skills; his thinking was concrete, and he had difficulties with abstract information.[6] Asberger's Disorder and PDD/NOS are disorders on the autistic spectrum. When she diagnosed him with Asberger's Disorder it was thought of as "high functioning Autism." Today, claimant's impairments are better described as an ASD. Dr. Kwak noted that claimant, like many individuals with an ASD, experience hypotonia, or softness of the muscles.

14. Dr. Kwak also determined that claimant suffered from Mood Disorder Not Otherwise Specified (NOS). She explained that she made this diagnosis because he was sad, and "it was clear that he did not have a thought disorder." In the year that she treated claimant, she did not see what she described as any "positive" or "negative" symptoms of Schizophrenia. She further explained that although people with Schizophrenia and people with ASD experience problems with social interactions, claimant looked "qualitatively" like

[6] The essential features of Asberger's Disorder are "severe and sustained impairment in social interaction" and the "development of restricted, repetitive patterns of behavior, interests and activities." (DSM-IV-TR, at p. 80.)

someone with a developmental disability because he was oriented to time and place and in touch with reality, but simply could not understand what was "going on."

15. Dr. Kwak treated claimant for almost a year. Her work was focused on improving claimant's social skills, which were profoundly impaired. Dr. Kwak recounted that claimant was confused by social situations. He wanted to engage socially, but he did not know how to carry on a conversation, understand social cues, or generalize what he learned to new situations. Dr. Kwak described claimant's difficulties with generalizing information from one setting to another as symptomatic of his "temporal lobe dysfunction." Dr. Kwak taught claimant perspective taking, also known as "theory of mind." Dr. Kwak explained that this process helped claimant see things from the perspective of others. She believed that he "clearly needed more services."

16. James Oh, M.D.: Dr. Oh is a psychiatrist with over 30 years of experience diagnosing and treating mental illness. He has treated patients in a variety of settings, including mental health clinics, hospitals, and in-patient jail psychiatric units. Of all of the experts who testified at the hearing, he had the most experience diagnosing and treating patients with Schizophrenia. At least half of his patients carry a diagnosis of Schizophrenia. He also treats patients who are dually diagnosed with both mental illness and developmental disability.

17. Dr. Oh evaluated claimant in 1999, when he was a psychiatrist at the APCTC. He treated claimant for almost two years. Dr. Oh initially diagnosed claimant with Major Depression with obsessive-compulsive traits and an indeterminate neurological disorder. About three months later, he changed his diagnosis to Asberger's Disorder and Anxiety Disorder Not Otherwise Specified (NOS). Dr. Oh prescribed anti-anxiety and anti-depressant medications, as well as a small dose of an antipsychotic medication that is often given to developmentally disabled clients to calm them down. Dr. Oh also evaluated claimant in 2009 and found him "essentially the same."

18. Dr. Oh firmly believes that claimant does not suffer from Schizophrenia, which is the most severe psychiatric diagnosis. According to Dr. Oh, any mental health professional who knew claimant for any length of time would not diagnose him with a psychotic disorder such as Schizophrenia. Dr. Oh noted that other psychiatrists at APCTC, who treated claimant after Dr. Oh, had prescribed Concerta, which is a stimulant.[7] Dr. Oh explained that it would be "malpractice to prescribe a stimulant to an individual who might be psychotic."

[7] Other psychiatrists and mental health professionals who evaluated claimant at the APCTC after Dr. Oh agreed that claimant suffered from a Pervasive Developmental Disorder and not Schizophrenia.

19. Dr. Oh testified at great length regarding the diagnostic criteria for Schizophrenia, and the reasons underlying his determination that claimant does not possess the hallmark characteristics of someone with Schizophrenia. First and foremost, claimant does not have Schizophrenia because he does not have a thought disorder, delusions or hallucinations, which are the "most important" symptoms of Schizophrenia. These "first ranked" symptoms are sometimes referred to as "positive symptoms" of Schizophrenia.[8] Claimant exhibited what might be viewed as "negative" symptoms of Schizophrenia, such as poor eye contact, poverty of speech, a flat affect, difficulties in initiating social interactions and other goal-directed behavior.[9] "Negative" symptoms of Schizophrenia are on the continuum with normal behavior and may be confused with symptoms of other disorders.[10] The presence of "negative" symptoms, without more, does not support a diagnosis of Schizophrenia.

20. Dr. Oh was particularly troubled by the fact that claimant was diagnosed with Schizophrenia in 2002, at age 25, when he was hospitalized for setting a fire and assaultive behavior in his home. The evaluation was performed by Alvin Mahoney, M.D., a psychiatrist who was unfamiliar with claimant save the short time it took to evaluate him. Dr. Oh describes Dr. Mahoney's diagnosis of Schizophrenia as an "unfortunate circumstance" that led to future evaluators drawing the same erroneous conclusion. He added that the evaluations performed during the course of acute hospitalizations are often done quickly and made in a vacuum. Dr. Oh questioned how claimant could be diagnosed with Schizophrenia by a doctor who had, essentially, just met him. Dr. Oh believes that claimant's diagnosis of Schizophrenia in 2002 predisposed subsequent psychiatrists to jump to the same diagnostic conclusion. Dr. Oh also disagreed with other mental health professionals who diagnosed claimant with Manic-Depressive Disorder and Psychotic Disorder Not Otherwise Specified, for the simple reason that claimant did not exhibit symptoms of mania or psychosis. Dr. Oh's analysis of the impropriety of claimant's initial diagnosis of Schizophrenia while he was hospitalized, and the impact that such misdiagnosis had in predisposing claimant to such misdiagnoses in the future was extremely persuasive.

21. Dr. Oh opined that claimant's childhood impairments in social interaction and reciprocal language were not symptoms of childhood onset of Schizophrenia. He explained that childhood onset of Schizophrenia is "very, very rare" and should not be confused with the symptoms associated with claimant's Pervasive Developmental Disorder. According to Dr. Oh, claimant had "too many signs and symptoms of developmental delay to evoke" childhood onset Schizophrenia. Because psychotic symptoms "can show up with anxiety and trauma" and "go up and down" it is important that a diagnosis of Schizophrenia be made "over time." Additionally, because symptoms of Schizophrenia may be confused with a

[8] DSM-IV-TR, at p. 299.

[9] DSM-IV-TR, at p. 299.

[10] DSM-IV-TR, at p. 301.

Pervasive Developmental Disorder, the DSM-IV-TR requires that if there is a history of a Pervasive Developmental Disorder, a diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are present for at least a month. While it is possible for Schizophrenia to co-exist with a Pervasive Developmental Disorder, according to the DSM-IV-TR, individuals with a Pervasive Developmental Disorder only "occasionally" develop Schizophrenia. (DSM-IV-TR, at p. 311.)

22. According to Dr. Oh, claimant's "main difficulty" was in the area of social interactions. He wrote:

> This area is the central deficit of his illness. He cannot process social information, so he continually gets into arguments, conflicts and imagined slights [with] people he meets. He would have significant difficulty in a work setting (e.g., he was barely able to do community service as part of his shoplifting sentence).

Dr. Oh opined that claimant's psychological symptoms stemmed from Asberger's Disorder, a condition which impaired claimant's social judgment and interactions with others. Regarding the impact that his developmental disorder has on his overall functioning, Dr. Oh wrote:

> His brain disorder (Asperger's) also influences his attention and concentration. He has failed nearly all his efforts at finishing a degree in college and he has never held down a job.

Dr. Oh wondered why claimant was not a regional center client. In part, he attributed this anomaly to his parents' shame at having a child diagnosed with a developmental disability.

23. Michael Shore, Ph.D.: Dr. Shore is a clinical psychologist with a specialty in neuropsychology. He has extensive experience assessing individuals with mental illnesses and developmental disabilities. On October 18, 2010, he evaluated claimant and submitted a report. As part of his evaluation, he reviewed claimant's records, including RCEB reports, psychological evaluations, and school assessments, and interviewed claimant, his family and his counselor at CAL.

24. Dr. Shore reviewed the opinions of various mental health professionals and noted that, broadly speaking, two "camps" existed: those who thought claimant was mentally ill and those who opined that he was developmentally disabled. At the outset, Dr. Shore noted that claimant was a difficult subject to test or interview because he was sometimes difficult to understand, and he did not easily respond to questions, often pausing for long periods of time or veering off on a tangent. Since intelligence testing had already been performed, Dr. Shore did not repeat administration of such tests.

25. Dr. Shore opined that prior evaluations lacked in-depth assessments of claimant's executive and adaptive functioning. Dr. Shore performed testing to determine claimant's level of executive functioning, which he described as "a person's ability to adapt to novelty, problem solve, and regulate ongoing plans of behavior." Claimant's performance on these tests showed that claimant's "core" limitation is in the area of executive functioning, particularly in his ability to solve problems and apply his knowledge to new situations. Claimant knows how to perform certain tasks, but he simply cannot execute skills effectively. Regarding claimant's executive dysfunction, Dr. Shore explained:

> This key compromise lies at the heart of Jung's disability, this that [sic] even as skill may have been mastered, even has he has practiced and practiced that skill far past mastery, the execution of that skill in the real world is subject to radical compromise, for executive function is not so much a compromise in skill learning per se, but one of impaired skill expression.

26. In order to obtain a comprehensive picture of claimant's adaptive functioning, Dr. Shore visited claimant's apartment and took claimant on a community outing. He observed that claimant had significant limitations in his capacity for independent living, economic self-sufficiency, and self-direction and self-care skills. Overall, he observed that claimant was unable to function independently. Instead, he required cues and supervision to complete self-care and household tasks. Dr. Shore's observations were consistent with the results he obtained from the Vineland Adaptive Behavior Scales II, Interview Form (Vineland), which he administered to claimant's parents. These results suggested a "broad compromise in adaptive behavior skills."

27. Dr. Shore noted that claimant's apartment was a "mess, trash spread about, dishes piled up, food out on the counter, clothes in disarray, his bed unmade." Claimant makes his own breakfast of cereal or toaster waffle, but he needs reminders to attend his daily program at CAL. Claimant bathes on his own, but needs reminders to do so. He has learned how to do his laundry, but requires supervision. Claimant's fine motor skills are impaired, as evidenced by his difficulty tying his shoes. According to Dr. Shore, claimant handles money like "kids, he doesn't count change and just buys stuff without looking around." Claimant's mobility is impaired in that he is unable to use public transportation on his own. He cannot safely drive. When Dr. Shore took him out into the community, claimant could not safely navigate traffic lights at a busy intersection, and he did not show safety awareness when walking past driveways. Claimant was able to walk to a nearby shop and purchase a snack. According to Dr. Shore, claimant does not fit the diagnostic profile of someone with Asberger's Disorder because his developmental and adaptive behaviors are more compromised than someone with Asberger's Disorder.

28. Emotionally, Dr. Shore found that claimant exhibited a restricted range of expression. Claimant hesitated before speaking, but his language was clear and coherent, albeit concrete. Claimant has limited conversational skills. He does not know how to carry on a conversation or respond to social cues, and he remains isolated. Claimant was able to

express loneliness and sadness. He appeared anxious, and had limited eye contact. Claimant is, however, aware of his anxiety. Dr. Shore opined that claimant developed psychiatric problems, such as anxiety and depression in response to his developmental difficulties, particularly social problems. Dr. Shore did not believe that claimant's symptoms of anxiety or depression rose to the level of a disorder under the DSM-IV-TR. He noted that claimant had done well on a low dose of antipsychotic medication, which is often used to control agitation and anxiety.

29. According to Dr. Shore, Schizophrenia is "not subtle," it is "dramatic" and one of the easiest psychiatric illnesses to diagnose. For a number of reasons, Dr. Shore thought that Schizophrenia was a "poor [diagnostic] fit." First, claimant's history does not fit the profile of childhood onset of Schizophrenia, where "everything is normal" until age eight or so. Claimant had a number of childhood language, motor and functional delays.[11] These developmental delays are "important" because they demonstrate that claimant "was not normal" from a young age. Second, claimant does not fit the profile of someone with adult onset of Schizophrenia because he did not have a "precipitant break." Third, claimant did not exhibit hallmark symptoms of Schizophrenia. Dr. Shore did not find evidence that claimant was paranoid or delusional, and his thinking and speech did not suggest that he had a thought disorder. Finally, Dr. Shore noted that claimant's adaptive functioning did not improve with medication, as one would likely see if he suffered from Schizophrenia.

30. With the exception of claimant's insistence that he can play basketball as well as an NBA player, Dr. Shore found that claimant's assessment of his capabilities was "absolutely accurate." Claimant's wish to see himself as a basketball star is a "persistent false belief" or "magical thinking" and not a delusion, according to Dr. Shore. Dr. Shore explained that while claimant has, at times, acted suspicious and irritable, these symptoms stem from his difficulty with social interactions and his social isolation, both of which can lead to mistrust and frustration, and not from a psychotic disorder.

31. Dr. Shore diagnosed claimant with PDD/NOS, moderate severity. Dr. Shore explained:

> With this condition he has a poor capacity to practically learn, poor adaptive reasoning/problem solving, poor ability to abstract, to generalize and profit from experience, and ultimately then the limited functional independence that comes from this impairment.

[11] Dr. Shore pointed to the fact that claimant had difficulty showering and brushing his teeth at a young age.

32. Dr. Shore noted that individuals with PDD/NOS who are in a "crisis" may act "crazy" or experience delusions:

> Finally, those with PDD NOS can have psychiatric crises, relatively brief periods of time in which they may display more disorganized, more regressed, more psychotic symptoms, and be mistaken as having Schizophrenia during such periods. Outside of these crises, while emotional issues and behavioral issues can endure, frank psychotic symptoms are absent -- such is so for Jung, such fits as well.

He theorizes that claimant was so emotionally overwhelmed in Alaska that it "put him over the edge." This accounts for his diagnosis of Schizophrenia. But, these delusions are transitory, and the content of any such delusions are not "bizarre" like those exhibited by individuals with Schizophrenia. Dr. Shore's testimony on this point was particularly convincing in that it accounted for the full range of claimant's symptoms.

33. Although he could not pinpoint the reason for claimant's disorder, Dr. Shore theorized that his Pervasive Developmental Disorder might have been caused by his seizures. Whatever the cause, claimant's condition is "something he was born with." He did not think that claimant suffered from Autistic Disorder because he did not possess the requisite quality or quantity of disturbances required by the DSM-IV-TR. He also thought that claimant's compromises in adaptive functioning and language delays were more severe than one who suffers from Asberger's Disorder.

34. Although claimant's IQ is higher than someone with mental retardation, claimant's condition is similar to someone with mental retardation in that both conditions involve defects in executive functioning. According to Dr. Shore, individuals with mental retardation need repetitive skills training to improve their adaptive living skills, including vocational training. Claimant also requires such services on a life-long basis. For this reason, he recommended that claimant be made eligible for regional center services based upon the fifth category.

35. Nancy Perry, Ph.D.: Dr. Perry is an expert in evaluating and treating Autistic Spectrum Disorders. She is the Clinical Director of CAL, a supportive living program that offers group and individual services to clients who suffer from ASD's. CAL does not cater to individuals with serious mental illnesses. CAL's clients live in apartments and are supervised by counselors. CAL provides the following services to its clients: living skills, money management, grooming, appropriate dress, menu planning, food shopping and preparation, vocational training, and use of community resources and public transportation.

36. Dr. Perry carefully screens potential clients to ensure they are a good fit with the program and clients at CAL. In October 2009, Dr. Perry screened claimant. She determined that claimant would be a good fit with the CAL community because, like other CAL clients, claimant possesses "profound deficits" in executive functioning. Her

conclusion was based upon claimant's impaired ability to initiate actions, his inability to think about the consequences of his actions, his lack of mental flexibility, his difficulty in understanding sequencing of events, his poor judgment, and his lack of self-monitoring and self-awareness. For example, he did not understand why people didn't talk to him; he could not plan his day; and although claimant had a good memory, he could not retrieve the information he needed to take care of himself on a daily basis. Dr. Perry observed that claimant was on the "lower functional level" of the clients at CAL. Further, claimant did not accept that he has a disability; he was adamant about that.

As a result of his deficits, claimant functions like someone who is mentally retarded. The services that claimant receives from CAL are similar to the services that individuals with mental retardation receive. The services are delivered by way of hands-on learning with repetition. Dr. Perry opines that claimant will need services indefinitely in that his condition is life-long. She hopes that, with services, claimant can learn to live and socialize on his own.

37. Dr. Perry did not think that claimant had Schizophrenia because he did not possess a thought disorder. She also did not think that he had Asberger's Disorder because he did not have "profound eccentric interests," and his speech patterns lacked the fluidity that one sees in individuals with Asberger's Disorder. Dr. Perry believes that RCEB clinicians missed claimant's developmental disability because they gave "short shrift" to claimant's delayed developmental milestones, his difficulties in school, and his difficulties socializing.

38. Other Psychiatric and Psychological Evaluations: Claimant received additional evaluations by psychiatrists and psychologists whose written reports were submitted into evidence. Insofar as these clinicians did not testify at the hearing, their written reports are of limited evidentiary value. The conclusions, however, are briefly summarized, as follows:

a. Lisa M. Doi, Ph.D.: Dr. Doi performed a psychological evaluation on August 16, 1999. She diagnosed claimant in connection with his application to the North Los Angeles Regional Center. She issued a report which states that claimant suffers from Bipolar Disorder NOS and Psychotic Disorder NOS. Dr. Doi opined that claimant was not eligible for regional center services.

b. Alvin Mahoney, M.D.: Dr. Mahoney evaluated claimant in December 2002, following his admission to the acute psychiatric unit at Mission Community Hospital on a 72-hour hold. Dr. Mahoney diagnosed claimant with Schizophrenia.

c. Ophelia Barte, M.D.: Dr. Barte evaluated claimant in December 2005, following his admission to the acute psychiatric unit at Mission Community Hospital on a 72-hour hold. Dr. Barte diagnosed claimant with Schizoaffective Disorder and Intermittent Explosive Disorder.

d. Janet Dipreta, M.D.: Psychiatrist Dr. Dipreta evaluated claimant at Anchorage Community Heath Services, when she treated him from 2007 to 2009. She initially diagnosed claimant with Schizophrenia, and later, included the diagnosis of Asberger's Disorder.

e. Catherine L. Scarf, Ph.D.: Dr. Scarf performed a psychological assessment of claimant on September 12, 2009, in connection with his application to CAL.[12] Dr. Scarf concluded that claimant met the DSM-IV-TR criteria for Autistic Disorder.

RCEB EVIDENCE

39. Assessment history: Claimant applied for regional center services in Los Angeles in 1999, and his application was denied. In 2009, claimant applied to RCEB for regional center services. He was initially assessed by a RCEB team that consisted of RCEB Staff Physician Frankie Moore, M.D., and RCEB Staff Psychologist Myles R. Friedland, Ph.D. The initial team was unable to determine if claimant was eligible for services, so claimant was referred for another team evaluation, consisting of Dr. Fujita., RCEB Staff Psychologist Faith Tanner, Psy.D., and RCEB Intake and Assessment Manager and Barbara Scapelitte. RCEB's assessment team members Drs. Fujita and Tanner testified to their findings at the hearing, as set forth below.

40. Paul Fujita, M.D.: Dr. Fujita has extensive training and experience as a developmental pediatrician, and particularly, in evaluating individuals for regional center eligibility. He has little experience in diagnosing Schizophrenia and no experience treating it. Dr. Fujita reviewed claimant's records, interviewed claimant's mother, with his sister acting as an interpreter, and interviewed claimant. He did not perform any psychological testing on claimant. Claimant was difficult to assess because he did not finish sentences or thoughts, and he perseverated about certain subjects, while avoiding others. In addition, his insight and memory of basic events appeared impaired.

41. Dr. Fujita concluded that claimant's clinical presentation and history is better explained by a diagnosis of Schizophrenia than it is by a diagnosis of Autistic Disorder, or another Autistic Spectrum Disorder. He rejected the notion that claimant has Autistic Spectrum Disorder and Schizophrenia; instead, he asserted that claimant suffers solely from Schizophrenia. He explained that once he determined that claimant's symptoms were best accounted for by a diagnosis of Schizophrenia and not a developmental disability, he did not think it was necessary to assess claimant's eligibility under the fifth category.

[12] In addition to her private practice, Dr. Scarf is the Chief Psychologist at the North Los Angeles Regional Center. According to Hui, Dr. Scarf did not want to testify at the hearing because she was "uncomfortable" testifying against another regional center.

42. Dr. Fujita determined that claimant exhibited a formal thought disorder and delusions, which are hallmark "positive" symptoms of Schizophrenia. According to Dr. Fujita, claimant exhibited thought blocking and appeared to have difficulty in providing a coherent answer to Dr. Fujita's questions. Claimant also talked about his belief that he could play basketball better than Michael Jordan, a belief which Dr. Fujita interpreted as evidence of grandiosity and delusional thinking. Dr. Fujita thought that claimant exhibited grandiose ideas of reference because claimant stated that a Nike commercial was about him. Additionally, Dr. Fujita saw a process of magical thinking in claimant's statement that he stole razors in order to "get back at people" he didn't like.

43. Dr. Fujita also opined that claimant exhibited "negative" symptoms of Schizophrenia, such as a flat affect with a depressed mood, decreased eye contact, awkward social interactions, poverty of speech, lack of goal directed behavior and reduced body language. These symptoms of Schizophrenia "overlap" with symptoms of Autistic Disorder and Asberger's Disorder. Dr. Fujita believes that other clinicians misdiagnosed claimant with a Pervasive Developmental Disorder when claimant's true problem is that he has Schizophrenia.

44. Dr. Fujita believes that the psychiatrists and psychologists who diagnosed claimant with a developmental disability confused claimant's poor executive functioning, poor social skills, abnormal language and impaired adaptive living skills as symptoms of an ASD. While Dr. Fujita allows that these symptoms could be viewed as part of an ASD, he believes that claimant's symptoms are "better accounted for" as symptoms of Schizophrenia. Dr. Fujita believes that claimant's developmental history and presentation of symptoms is dissimilar from someone with an ASD for several reasons: First, a developmental disorder emerges at an early age, whereas Dr. Fujita believes that claimant's symptoms did not emerge until he was in high school. Second, Dr. Fujita opines that unlike someone with a developmental disability who presents a stable set of symptoms, claimant's symptoms progressively worsened as he grew older. Third, Dr. Fujita contends that had claimant been developmentally disabled, that fact would have shown up in early school or other reports; instead, claimant was not diagnosed with an ASD until age 22. Fourth, Dr. Fujita believes that the evaluation he performed with Dr. Tanner, which he described as "consensus best estimate," is superior to the evaluations performed by individual clinicians.

45. Dr. Fujita agrees that claimant suffers from a host of impairments in social interactions and adaptive functioning. He firmly believes that these impairments stem from his psychiatric condition (Schizophrenia) and not a developmental disability.

46. Dr. Fujita made the following recommendations for treatment: psychiatric treatment and medication; day treatment programming emphasizing social, adaptive and vocational training; residential services that provide for basic needs, education about his psychiatric disorder, and psychotherapy. Dr. Fujita emphasized that his treatment recommendations are geared, first and foremost, to treating claimant's Schizophrenia.

47. Faith Tanner, Psy.D: Dr. Tanner also has extensive experience in evaluating individuals for regional center eligibility. She reviewed claimant's records and met with claimant, during which time she administered the Autism Diagnostic Observation Schedule (ADOS). She did not administer the complete ADOS was because claimant's behavior was "inconsistent with an ASD and time restraints, since he continually returned to previous questions."

48. Dr. Tanner determined that claimant did not meet the diagnostic criteria for either Autistic Disorder because he did not exhibit restrictive repetitive and stereotyped patterns of behavior, interests or activities. She also determined that he did not fit the diagnostic criteria for Asberger's Disorder based upon his language delay. Dr. Tanner thought that claimant appeared "anxious" and "paranoid." She interpreted his long pauses before answering her questions as thought blocking, and she interpreted claimant's beliefs regarding his basketball abilities as evidence of a delusional thought process. She also thought that claimant's difficulties began later in life than she would expect to see in someone who had an ASD. For these reasons, she opined that claimant suffered from a mental illness and not an ASD.

LEGAL CONCLUSIONS

1. The State of California accepts responsibility for persons with developmental disabilities under the Lanterman Developmental Disabilities Services Act. (Act). (Welf. & Inst. Code, § 4500, et. seq.)[13] The purpose of the Act is to rectify the problem of inadequate treatment and services for the developmentally disabled and to enable developmentally disabled individuals to lead independent and productive lives in the least restrictive setting possible. (§§ 4501, 4502; *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384.) The Act is a remedial statute; as such, it must be interpreted broadly. (*California State Restaurant Association v. Whitlow* (1976) 58 Cal.App.3d 340, 347.)

2. As defined in the Act, a developmental disability is a "disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual." (§ 4512, subd. (a).) The Act provides that the term "developmental disability" shall include mental retardation, cerebral palsy, epilepsy, autism, and what is commonly referred to as the fifth category. (*Ibid.*) The fifth category includes "disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation." (*Ibid.*)

[13] All citations are to the Welfare and Institutions Code unless otherwise indicated.

3. Under the Act, conditions that are solely psychiatric in nature, or solely learning or physical disabilities, are not considered developmental disabilities. (Cal. Code Regs., tit. 17, § 54000, subd. (c)(1)(2)(3).)

4. The term "substantial handicap" is defined by title 17, California Code of Regulations, section 54001, subdivision (a), as a "condition which results in a major impairment of cognitive and/or social functioning" that requires "interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential." Whether or not an individual suffers from a substantial disability in cognitive and/or social functioning depends on his functioning in a number of areas, including: communication skills, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency. (Cal. Code Regs., tit. 17, § 54001, subd. (b).) Cognitive ability is defined by title 17, California Code of Regulations, section 54002 as "the ability of an individual to solve problems with insight, to adapt to new situations, to think abstractly, and to profit from experience."

5. Pursuant to section 4512, subdivision (l), the term "substantial disability" is defined as "the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person: (1) Self-care. (2) Receptive and expressive language. (3) Learning. (4) Mobility. (5) Self-direction. (6) Capacity for independent living. (7) Economic self-sufficiency."

6. In the recent case of *Samantha C. v. State Department of Developmental Services (2010)* 185 Cal.App.4th 1462, the Court of Appeal analyzed the provisions of section 4512 in the context of an appeal from a regional center determination that a claimant was not eligible for services under the fifth category. The claimant, Samantha C., alleged that she was eligible for services because she had a substantially disabling condition which required treatment similar to that required for individuals with mental retardation. Samantha C. presented a similar profile to the claimant in the instant case: At the age of 21, and then 23, Samantha C. applied for services on the grounds that she required services and treatment similar to someone with mental retardation. She had an average IQ. She was diagnosed with a cognitive disorder, not otherwise specified, PDD/NOS and a learning disorder, but had gotten some good grades in high school and junior college. She had no friends and suffered from depression, anxiety and a possible personality disorder. Her adaptive functioning skills were significantly impaired, and on a par with mentally retarded people. Notably, she possessed solid conversational skills, and was capable of insight, but did not always act upon it. It was postulated that claimant suffered birth injuries that affected her brain, and that her deficits in cognitive and adaptive functioning, in part, stemmed from her brain injuries. Expert testimony established that she would benefit from some of the same services required by people with mental retardation, but that she would need different service providers than those serving mentally retarded individuals. The regional center concluded that, based upon Samantha C.'s relatively high IQ and the nature of services that she required, she was ineligible for services. It also took the position that Samantha C.'s difficulties stemmed from her psychiatric and learning disorders.The court held that the trial court's finding of

ineligibility under the fifth category was not supported by substantial evidence. In so doing, the Court of Appeal rejected the regional center's argument that Samantha C. was too intelligent to qualify for eligibility under the fifth category. It held that a regional center cannot disqualify an individual for eligibility based upon a comparatively high IQ, where that person otherwise establishes that he has a substantially disabling condition as that term is defined by section 4512. (*Samantha C. v. State Department of Developmental Services*, *supra*, at p. 1494.)

The court also noted that the services Samantha C. required, such as help with cooking, money management, public transportation, and independent living skills, were similar to the services provided to mentally retarded individuals. The fact that the method of service delivery to Samantha C. differed from those used by individuals with mental retardation was also determined to be an insufficient basis for denying eligibility under the fifth category. (*Samantha C. v. State Department of Developmental Services*, *supra*, at p. 1494.) The court stated:

> Because educational and teaching methods may differ even among those with mental retardation, the reference in section 4512(a) to "treatment similar to that required for individual with mental retardation" cannot refer to educational or teaching *methods* but to the *types of treatment* required such as independent living skills training. (*Ibid*.)

The court also reaffirmed that, under the Act and its implementing regulations, the fact that an individual also requires mental health treatment does not disqualify him from fifth category eligibility if he otherwise meets the requirements of section 4512.

DISCUSSION

Does claimant suffer from a disabling condition?

Claimant presents a complex set of symptoms that have confounded even the most seasoned and qualified mental health professionals. Indeed, RCEB convened two eligibility teams in order to determine claimant's eligibility for services.

The testimony offered by claimant's treating psychiatrist and psychologist, Drs. Oh and Kwak as to claimant's diagnosis and symptomatology, and the assessment of Dr. Perry, were particularly persuasive because of their familiarity with claimant over a substantial period of time. Dr. Oh's determination that claimant did not exhibit a thought disorder, delusions or hallucinations, the hallmark symptoms of Schizophrenia, and his conclusion that claimant exhibited too many childhood symptoms of a developmental disorder to evoke a diagnosis of Schizophrenia, was the most convincing, not only because of his familiarity with claimant, but also because his expertise in diagnosing and treating Schizophrenia was unequalled by any other witness. Similarly, his explanation for the reasons for claimant's

initial misdiagnosis of Schizophrenia, and the impact that this had on later diagnoses, was extremely persuasive. For these reasons, his determination that claimant does not have Schizophrenia was more persuasive than the contrary opinions expressed by Drs. Fujita and Tanner.

Dr. Perry's assessment of claimant's symptoms as most consistent with individuals with Autistic Spectrum Disorder, and her observations regarding claimant's profound executive dysfunction was also convincing insofar as she has known claimant since late 2009. Based upon her familiarity with claimant, she placed him in the lower level of functioning of the CAL client population.

Dr. Shore's assessment of claimant's substantial impairments in executive functioning was also very persuasive because he had the unique opportunity to observe claimant's degree of adaptive functioning in the community, and because his analysis accounted for and explained claimant's complex set of symptoms. As he pointed out, it is not unusual for individuals with PDD/NOS to exhibit relatively brief periods of psychotic symptoms which may be mistaken for Schizophrenia.

While the evidence did not establish that claimant meets the diagnostic criteria for Autistic Disorder, the testimony of Drs. Kwak, Oh, Perry and Shore established by a preponderance of the evidence that claimant suffers from an ASD. The weight of the evidence suggests that PDD/NOS is the most appropriate diagnosis for claimant. The fact that these clinicians disagree as to the exact diagnosis under the DSM-IV-TR, be it PDD/NOS or Asberger's Disorder, is not as important as the fact that they universally agree that claimant has an ASD. Insofar as claimant's psychiatric problems co-exist with his developmental disorder, they do not preclude claimant from regional center eligibility.

While the assistance provided to claimant by his family when he was growing up masked the severity of claimant's symptoms, this does not abrogate the fact that such a disorder existed in claimant when he was a child. Additionally, while it is true that claimant's difficulties increased in his later high school years and in his late 20's, these difficulties emerged as claimant tried, without success, to study, and later, take care of his daily needs. These aspects of claimant's history do not weaken his contention that he suffers from an ASD.

Is claimant's developmental disability substantial?

In the instant case, the evidence established that as a result of claimant's PDD/NOS and executive dysfunction, he suffers from a host of impairments in cognitive and social functioning. His deficits in executive functioning impair his ability to plan, problem-solve, take in new information and apply it to particular situations. His PDD/NOS impairs his ability to understand what others are communicating to him, as well as his ability to interact socially and form friendships.

The evidence demonstrating claimant's significant functional limitations in self-care, self-direction, receptive language skills, mobility, and capacity for independent living and capacity for economic sufficiency includes the following: Claimant's lack of pragmatic language skills makes it difficult for him to engage with others. Claimant cannot live or work independently because he cannot perform basic tasks of daily living such as shopping, cooking, and paying bills. Claimant is difficult to treat because even if he learns a skill, his executive dysfunction impairs his ability to apply what he learned to real-life situations. He cannot safely make his way around the community on his own because he cannot navigate traffic or manage public transportation. These impairments constitute a "substantial disability" as that term is defined by the Act. (§ 4512, subd. (l).) Thus, in spite of claimant's average cognitive abilities, his adaptive functioning skills are akin to someone who is mentally retarded.

RCEB argues that claimant is ineligible for regional center services because his impairments in adaptive functioning stem from a psychiatric disorder rather than a developmental disability. This argument lacks merit. The presence of a psychiatric disorder does not disqualify an individual for eligibility unless it is his sole condition. Such is not the case here. The evidence amply demonstrated that claimant's impairments in adaptive functioning stem from his executive dysfunction and PDD/NOS, as well as various psychiatric conditions.

Does his disabling condition require treatment similar to that required for individuals with mental retardation?

Claimant established that, as a result of his PDD/NOS and executive dysfunction, he requires treatment similar to that typically required for mentally retarded individuals. Claimant's service needs are similar to someone with mental retardation because, like someone who is mentally retarded, he has significant limitations in adaptive functioning and requires treatment that spans a number of disciplines. Claimant requires repetitive instruction geared to improving his adaptive living skills and his social skills. He also requires vocational training and assistance, and ongoing management of his psychiatric medication and mental health.

CONCLUSION

It is determined that the weight of the evidence establishes that, as a result of claimant's disabling condition, he requires treatment similar to that required for individuals with mental retardation. His disability, which arose before age 18, is substantially disabling and is expected to continue indefinitely. Accordingly, claimant is eligible for regional center services.

ORDER

The appeal of claimant, Jung Won S., from RCEB's notice of proposed action dated August 12, 2010, is granted. Jung Won S. is eligible for RCEB services.

DATED: May 27, 2011

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DIANE SCHNEIDER
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.